Legislative Report

To

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services

Senate Appropriations Committee on Health and Human Services

House of Representatives Appropriations Subcommittee on Health and Human Services

Fiscal Research Division

COMMUNITY SUPPORT SERVICES

Session Law 2007-323
House Bill 1473
Section10.49 (ee)

March 2008

NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES AND THE DIVISION OF MEDICAL ASSISTANCE

COMMUNITY SUPPORT SERVICES

March 2008

Session Law 2007-0323, passed by the General Assembly of North Carolina in July 2007, requires the Department of Health and Human Services to take multiple actions related to management of community support services and to provide a "*detailed report on the implementation and status of each of the activities"* to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services and the Fiscal Research Division in March 2008. This report is submitted to fulfill those requirements.

Section 10.49.(ee) of the legislation states: "*For the purpose of avoiding over-utilization of community support services and over-expenditure of funds for these services, the Department of Health and Human Services shall immediately conduct an in-depth evaluation of the use and cost of community support services to identify existing and potential areas of overutilization and overexpenditure. The Department shall also adopt or revise as necessary management policies and practices that will ensure that at a minimum:*

> *(1) There is in place a list of community support services that are appropriate to meet the critical needs of the client and are cost effective;*

A report outlining the list of services and the staff credentials appropriate to provide each service was submitted to the legislative bodies outlined above in November 2007. It is available on the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services website at http://www.ncdhhs.gov/mhddsas/statspublications/reports/legreport-list-of-community-support-services-1107.pdf

Medicaid Policy 8A, "Enhanced Mental Health and Substance Abuse Services", Attachment D located on the Division of Medical Assistance website http://dhhs.state.nc.us/dma/bh/8A/pdf also has the list, as part of the official Medicaid coverage policy for Community Support.

> *(2) Community support services are appropriately utilized based on the critical needs of the client, and utilization is monitored routinely to ensure against overutilization;*

Prior authorization is required for community support services that extend beyond the four (4) unmanaged Qualified Professional hours for adults and the eight (8) unmanaged

Qualified Professional hours for children and adolescents. The unmanaged hours do not require prior approval and are intended for the development of the Initial Person-Centered Plan. Requests for additional community support services require the approval of the Medicaid-approved vendor, ValueOptions, for Medicaid eligible consumers or the Local Management Entity (LME) for state-funded consumers. In authorizing services, ValueOptions and the LMEs review the requests using criteria of medical necessity and critical needs identified in the Person-Centered Plan.

In addition, LMEs are required to conduct post-payment reviews to ensure that the services delivered are clinically appropriate and in accordance with federal and state statutes as well as with relevant DHHS policies, manuals, and communications. The Department and LMEs conducted post-payment reviews in 2007 on all individuals who were receiving community support services in excess of 12 hours per week, a total of 4,155 adults and 7,646 children and adolescents. The reviews indicated overutilization of community support services since more than a third of services received by adults (36%) and children and adolescents (35%) were considered to be not medically necessary. Fifty-four percent (54%) of community support services for both groups were considered to be medically necessary but the duration and intensity were not considered appropriate. The remaining consumers received community support services that were medically necessary as well as appropriate in duration and intensity (NC Department of Health and Human Services, Monthly Report on Community Support Services, October 2007).

The Division of Medical Assistance monitors on a weekly basis the ValueOptions' authorizations, reductions and denials data. The Department also analyzes paid claims data for Medicaid at each Medicaid check write, which is about every two weeks and state funded services on a monthly basis and submits findings on the utilization of Community Support and other services in monthly reports to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services, the Senate Appropriations Subcommittee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services and the Fiscal Research Division. These monthly reports on Community Support Services are described in greater detail in the response to Section 10.49.(ee) (10).

Finally, as part of the administrative and governance functions cited in the contract with the Department, the LMEs are required to analyze and process service authorization and claims payment data received from DHHS to inform management decision-making in such areas as identification of high cost/high need consumers, provider billing patterns and trends and utilization of various services in the service array.

(3) *That expenditures for services are controlled to the maximum extent possible without unnecessarily impairing service quality and efficiency;*

Mechanisms for the control of expenditures exist at the individual and aggregate levels. At the individual level, prior authorization is required for community support services, as outlined above. To control expenditures for services at the aggregate level, the

Department analyzes paid claims for Medicaid at each Medicaid check write and State funded services on a monthly basis. Moreover, LMEs routinely receive paid claims data for Medicaid and state funded services so that they can perform required monitoring of services.

(4) Service providers are fully competent to provide each service, to provide the service in the most efficient manner, and that services and providers meet standards of protocol adopted by the Department. To this end, endorsement shall be based on compliance with: a Medicaid service-specific checklist, rules for Mental Health, Developmental Disabilities and Substance Abuse Services, client rights rules in community Mental Health, Developmental Disabilities and Substance Abuse Services, the Medicaid service records manual, and other Medicaid requirements as stipulated in the participation agreement with the Division of Medical Assistance. In accordance with G.S. 122C-115.4, an LME may remove a provider's endorsement;

Provider endorsement is one of the responsibilities of a Local Management Entity as specified in G.S 122C-115.4. Under the same statute, a Local Management Entity may also remove a provider endorsement.

To ensure that service providers are fully competent to provide each service and that services and providers meet standards of protocol adopted by the department, endorsement is based on compliance with the endorsement policy found in "Policy and Procedures for Endorsement of Providers of Medicaid Reimbursable Services" (Communication Bulletin # 44), the core rules stipulated in 10A NCAC 27G.0201-.0204 and other communications from the department , as well as endorsement review check sheets for Community Support (Child and Adult).

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the LME. Additionally, within three years of enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the Medicaid program. This includes national accreditation within the prescribed timeframe.

In its first year of implementation, provider endorsement included a transition phase-in where initial endorsements were conditional for up to 18 months from the date of enrollment in Medicaid. The period of conditional endorsement ended in September 2007. As of October 1, 2007, all new providers seeking endorsement must meet full endorsement criteria to be enrolled as a Medicaid provider.

(5) All community support services are subject to prior approval after the initial assessment and development of a person-centered plan has been completed;

The Introductory Person Centered Plan is for an individual who is new to the service system or who has been completely discharged with no services for 60 days. For a new consumer entering the service system through the Screening/Triage/Referral (STR) process, an Introductory Person-Centered Plan must be completed by a Qualified Professional (or licensed professional) from the chosen provider agency for community support services. The provision for an Introductory Person-Centered Plan allows the provider to quickly gather the information needed to request authorization from the Medicaid approved vendor.

Among the key elements that must be in the Introductory Person-Centered Plan is confirmation of medical necessity. The Person-Centered Plan must include the clinical information to support the medical necessity determination. Medical necessity is determined by generally accepted North Carolina and national mental health, substance abuse practice standards as verified by independent Medicaid consultants, or the LME for state-funded services.

In addition to the Introductory Person-Centered Plan, the completed Inpatient Treatment Review and Outpatient Review forms (ITR/ORF-2CTCM) from ValueOptions or the form issued by LMEs for prior authorization and the Person-Centered Plan Consumer Admission Form (for submission to the LME) are required to process an initial authorization. The provider is also expected to submit any additional clinical documentation or assessments, gathered to date of the initial authorization to assist the reviewer in determining the appropriate service and appropriate duration and intensity of the service.

Services that were authorized from an Introductory Person-Centered Plan are in effect for the duration indicated by the authorizing agency. Prior to the end of the first authorization period, a comprehensive clinical assessment must be completed in order for services to continue to be authorized. The results and recommendations outlined in the assessment must be addressed and incorporated into the Complete Person-Centered Plan. For further authorization to occur, a new ITR/ORF-2CTCM form and the Complete Person-Centered Plan must be submitted to ValueOptions or the LME. Additional information may be requested from the provider prior to the authorization decision being reached.

> (6) *Providers are limited to four hours of community support for adults and eight hours of community support for children to develop the person-centered plan. Those hours shall be provided only by a qualified professional. Providers that determine that additional hours are needed must seek and obtain prior approval. If additional hours are authorized, the LME may participate in the development of the person-centered plan as part of the care coordination and quality management function as defined in G.S. 122C-115.4;*

The service definition for Community Support –Adults (MH/SA) was modified with a March 1, 2008 effective date to implement the 4 hour limitation on unmanaged hours for adults. The service definition for Community Support – Child/Adolescent had previously

been modified to incorporate the 8 unmanaged hour limitation. These unmanaged visits apply only to recipients new to the service system.

LMEs may participate in the development of the person-centered plan through their care coordination and quality management functions if additional hours are authorized. The Department of Health and Human Services, LMEs, and staff of ValueOptions are working together to develop streamlined communication protocols to facilitate communication around high cost/high need consumers.

(7) *Based on standards of care and practice, a stringent clinical review process for authorization of services is implemented uniformly and in accordance with State guidelines;*

The Department has a stringent and standard clinical process for the authorization of services. Utilization management of covered services is part of the assurance of medically necessary service provision. Authorization, which is an aspect of utilization management, validates approval to provide a medically necessary covered service to eligible respondents. Services are based upon a finding of medical necessity which is determined by generally accepted North Carolina and national mental health, substance abuse standards of practice as verified by independent Medicaid consultants or the LME for state-funded services. They must be related to the recipient's diagnostic and clinical needs as documented by clinical assessments conducted by licensed professionals within their scope of practice and are expected to achieve the specific rehabilitative goals specified in the individual's Person-Centered Plan and in accordance with the requirements of the service definition. If the needed medical information is not yet completed when the initial prior authorization request is submitted, the appointment date(s) and historical clinical information must be included to justify the initial request. The initial authorization with variable timelines for resubmission is given to ensure the delivery of needed services. All clinical assessments must be completed prior to the submission of the next authorization.

Medically necessary services are authorized in the most economic mode as long as the treatment that is made available is similarly efficacious to services requested by the recipient's physician, therapist or other licensed practitioner. For Medicaid, authorization by ValueOptions is required according to published policy. For state-funded services, authorization is required by the LME prior to the first visit. ValueOptions and the LME evaluate the request to determine if medical necessity supports more or less intensive services.

(8) Additional record audits of providers are conducted on a routine basis to continually ensure compliance with Medicaid requirements;

The DHHS Interagency Memorandum of Agreement (MOA) between DMA and DMH/DD/SAS requires the two agencies to collaborate with each other on audit and review functions for Medicaid compliance. Under the same MOA, DMH/DD/SAS is required to undertake, with DMA participation, Medicaid compliance audits of randomly

selected providers of MH/DD/SA services, produce a report of the findings of these audits and ensure appropriate management of Medicaid services by assuring that LMEs meet readiness criteria for performing Medicaid service utilization management functions, when designated to do so. As required by the Centers of Medicaid and Medicare Services, DMA monitors the performance of DMH/DD/SA and the LMEs in conducting their respective duties outlined in the DMA and DMH/DD/SA MOA and the LME functions that receive federal financial participation.

The Scope of Work of the contract between LMEs and DHHS includes post-payment reviews as one of the administrative and governance functions of LMEs. The reviews are conducted to ensure that services delivered are clinically appropriate and in accordance with the NC Administrative Code, the DMH/DD/SAS Service Definitions Manual, Medicaid MH/DD/SA Service Policies, DHHS policies and communications, the Medicaid Provider Enrollment Agreement, the North Carolina General Statutes and the Federal Code of Regulations. As DMA's representative, the LME has the authority and responsibility to make clinical and administrative determinations relating to quality and quantity of services rendered by providers endorsed by the LME. The LME is required to work with DMA to identify high risk or high concern areas in which to conduct post-payment reviews at a level to be mutually agreed upon. Following completion of the post-payment reviews, the LME is required to report its specific findings to the DMA Program Integrity Unit using standard referral documents and protocols. Upon review of the information, DMA determines the appropriate sanctions or corrections.

Local Management Entities conducted service record reviews (medical record documentation reviews) on records identified in the post-payment review process as requiring further inquiry to assure appropriate documentation of services. The process entailed reviewing 19,577 events for 4,285 individual consumers served by 498 providers.

A Frequency and Extent of Monitoring (FEM) tool has been developed and is currently being implemented as a standardized instrument to ensure that providers remain in substantial compliance with endorsement criteria including national accreditation, first responder capacity and quality, compliance with data submission requirements, consumer rights protection, incident reporting and rights protection requirement, meeting defined quality criteria, adherence to evidence-based practices in the delivery of services and compliance with DHHS documentation requirements.

(9) *Post-payment clinical reviews are conducted at the local level to ensure that consumers receive the appropriate level and intensity of care;*

As noted in the response to item (2), the Department and Local Management Entities conducted post-payment reviews in 2007 on all individuals who were receiving Community Support services in excess of 12 hours per week. Additional post-payment reviews will be conducted in the future.

(10) Beginning October 1, 1007 and monthly thereafter, report to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services;

DHHS began submitting monthly reports on Community Support services to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services in October 2007.

As specified in the subsection, the monthly reports include the number of consumers of community support services by month, segregated by adult and child (10a); the number of units of community support services billed and paid by month, segregated by adult and child (10b); the amount paid for community support by month, segregated by adult and child (10c); the length of stay in community support, segregated by adult and child (10e); the number of clinical post-payment reviews conducted by LMEs and a summary of those findings(10f); the total number of community support providers and the number of newly-enrolled, re-enrolled, or terminated providers, and if available, reasons for termination(10g); the number of community support providers that have been referred to DMA's Program Integrity Section, the Division's "Rapid Action response" committee; or the Attorney General's Office (10h); the utilization of other, newly enhanced mental health services, including the number of consumers served by month, the number of hours billed and paid by month, and the amount expended by month (10i).

Because the information system previously did not specify whether the community support service provider was a qualified professional or paraprofessional, the monthly reports produced thus far have not identified the units provided by a qualified professional and those provided by a paraprofessional (10d). However, the Medicaid claims processing system was modified effective December 1, 2007 to allow for the identification of a community service provider as a qualified professional or paraprofessional. Accordingly, the monthly report on community supports for February 2008 that will be released in March 2008 will distinguish between the number of units of community services billed by qualified professionals from the number of units billed by paraprofessionals.

(11) *If possible, modify the Medicaid claims payment processing system so that providers will be required to identify, by claim, whether the service was provided by a qualified professional or a paraprofessional;*

As noted in the November 2007 Medicaid Bulletin and Implementation Memo # 36, providers were required to use additional modifiers for community support services billed with date of service effective December 1, 2007 to identify units of service provided by the Qualified Professional (QP) and the non-Qualified Professional. Modifier U3 is now used as the secondary modifier to identify a service rendered by a Qualified Professional

and U4 as the secondary modifier to identify a service rendered by a non-Qualified Professional).

(12) The Department of Health and Human Services and the Department of Public Instruction shall amend their Memorandum of Agreement to ensure that each local education agency develops its own list of approved providers and individual service providers authorized to provide services on campus as provided under the Federal Safe Schools Act;

DHHS and the Department of Public Instruction (DPI) have completed a review of all existing memoranda of agreements (MOAs) to be considered for such an amendment and relevant state and federal legislative requirements for citations and language needed for use in the agreement. In consultation with relevant DPI staff and representatives from the Local Education Agencies (LEAs), language has been drafted for use in a memorandum of agreement (MOA) between DHHS and DPI to meet this requirement. The Department has also reviewed samples of local contracts between LEAs and community support providers to assure compliance with Medicaid requirements and rules.

As an interim measure, DPI sent a memorandum dated February 8, 2008 to principals and directors of exceptional children's programs in all public schools regarding Community Support services in schools. The memorandum states that "(A)ccording to federal and state special education law, if the school believes that a student who has a disability must have a one-one-one assistant in order to attend school, the school is required to provide the service." It also reminds schools of their responsibility for providing education-related required services and supports to students with disabilities in the school setting to ensure that eligible students receive a free and appropriate education.

Section 10.49.(ee) also requires that this report "*include clear standards for determining local management entity capability to perform utilization review and utilization management. These standards shall include (i) determination of medical necessity; (ii) an authorization process that includes the use of standardized forms; (iii) concurrent review procedures; (iv) recipient appeals process; (v) minimum staffing requirements; (vi) requirements for data collection and reporting; and (vi) performance criteria for the LMEs and outside vendor.*"

As part of its contract with the Department to evaluate the performance of LMEs, Mercer Health & Benefits, LLC is evaluating the capacity of each LME to successfully perform utilization review functions for Medicaid services. The results of that evaluation will be included in the final report on LME performance due to DHHS by May 15, 2008.

Clear standards that have been developed to determine LME capability to perform utilization review and utilization management. The LMEs are expected to meet the standards specified in the RFP for Medicaid utilization review and all subsequent amendments. The major standards are described below.

(i) Medical necessity is determined based on the following elements:

- A diagnosis as defined by standard diagnostic nomenclatures (DSM-IV or its equivalent in ICD-9-CM). The patient must have been diagnosed with a psychiatric/substance abuse illness by a licensed professional within his or his scope of practice.
- The symptoms of the illness or condition must accord with those described in the DSM-IV. The diagnosis must have been arrived at prior to admission or submission of Utilization Review documents in a face-to-face encounter between the person and the professional who issues the diagnosis.
- An individualized treatment plan (Person-Centered Plan) appropriate for the person's illness or condition and clinical assessments and documentation to support the plan.
- A reasonable expectation that the person's illness, condition, or level of functioning will improve through the prescribed treatment.
- The treatment is safe and effective according to nationally accepted standards of clinical evidence generally recognized by clinical/treatment professionals.
- The treatment is the most appropriate and cost-effective level of care that can safely be provided for the person's immediate condition.
- The treatment should also be the least restrictive level of care that meets the medical needs of the consumer.
- The request falls within the requirements of the Medicaid Service Definition, American Psychiatric Association Practice Guidelines or The American Academy of Child and Adolescent Psychiatry Practice with the application of standard clinical knowledge of acceptance practice standards.
- All services must be reviewed by NC licensed clinical staff. Decisions regarding reductions/terminations or denials must be decided by NC Board Certified Psychiatrists, ASAM certified MD for decisions regarding Substance Abuse

(ii) An authorization process has been clearly defined. The process includes the use of standard authorization forms, such as the Inpatient Treatment Report (ITR) and the Outpatient Review Form (ORF 2) and the Outpatient Registration Form (ORF2SA). The forms are available on the ValueOptions website.

(iii) The Department and LMEs conduct concurrent review procedures in accordance with adopted policy. In addition to items cited in section (i), concurrent reviews also must demonstrate evidence of progress to address the presenting symptoms or challenges. If the identified strategies or treatment modalities are not producing the desired clinical outcomes, clinical modifications and plan revisions are required for continued authorization. Concurrent review schedules may vary based upon the individual needs but shall not exceed the review period authorized in policy.

Concurrent reviews are not the same as post payment reviews. Post Payment reviews and procedures are outlined above in items (8) and (9).

(iv) Consumers or legally responsible persons have the right to appeal a decision to reduce or deny services. The process for appealing decisions is standardized across all Medicaid services and prior authorization vendors. The Medicaid vendors must issue the notice of action letter within 1 business day of the decision. The DMA standardized letters are issued in English and Spanish and highlights of the letter include:

a. Identification of the service requested,
b. Documentation of the authorization action taken instead of granting the original authorization request that reduces, terminates or denies the request
c. Citation of the clinical reason for the decision to reduce, terminate or deny the request
d. Citation of the federal or state rule, standard or policy granting the authority to issue the decision
e. Inclusion of the details and timelines of requesting both informal and formal appeal request,
f. Notification of the application of Maintenance of Service (MOS) during appeal for concurrent reviews which are reduced or terminated and
g. Inclusion of forms requesting the appeal.

A service recipient or his/her legal representative may choose to appeal a decision either through an informal hearing by DHHS Hearing Office or a formal hearing by the Office of Administrative Hearings. Recipients have the right to continue to receive the service at the level previously in place (MOS) prior to the dispute until resolution of the appeal.

(v) Minimum staffing requirements to conduct utilization review (initial, concurrent, retrospective, post payment) include medical director, clinical director, licensed NC clinical staff to serve as care coordinators, Board Certified Psychiatrists, ASAM certified Physicians. Ratios are expected to meet the turn around time (TAT) established by DMA contract and to staff the clinical hearings. Current TAT is four (4) hours for inpatient and crisis/emergency requests, 5 days for regular requests and 15 days for EPSDT decisions. Physicians must defend their decisions in person for all OAH hearings. Written summaries by the physician are provided for all DHHS Hearings and are presented by licensed clinical staff. The Physician must be available via phone as necessary to participate in the hearing.

For all adverse actions based upon the absence of medical necessity, the denial must be made by a psychiatrist, a non-psychiatrist physician with specialized training in addiction or psychiatric disorders or a licensed clinical psychologist with five years post doctorate experience. Denials based upon compliance with an administrative requirement must be endorsed by a psychiatrist, a non-psychiatrist physician with specialized training in addiction disorders or licensed clinical psychologist with five years post doctorate

experience. The Contractor's psychiatrists shall be a child/adolescent psychiatrist if the recipient is under twenty-one (21).

DMA requires the following information so that the Division can verify credentials of the clinical staff:

- NC Licensure by the appropriate board or other licensing body;
- Hospital privileges of practitioner or individual or group providing hospital coverage, if applicable;
- Liability coverage in the amount required for participate
- Valid DEA or CDS certificate, as applicable;
- Board certification or eligibility, if the practitioner states that he/she is board certified or eligible on the application
- Malpractice and sanction history;
- Review of criminal background check for providers, owners and affiliates with five percent (5%) or more ownership;
- Review of individual clinical staff background checks, regardless of location; and
- Assurance that provider is not excluded from participation by Medicare or the OIG.

Additional staff are required to perform the following functions within the established performance criteria outlined in the contract: provider relations, clerical/administrative, data entry, letter production, information technology for application programming and networking and hardware design, data analysis, data transmission to fiscal agent, reports, contract management and business management

(vi). The Contractor shall provide reports of collected data that will assist the Division to manage its system of care for recipients with behavioral health and developmental disability disorders. Data may be requested by Division in a frequency, form and format necessary to meet its operational needs. The Contractor shall provide data for the following categories of activity: Annual Reports, Routine Reports and Ad Hoc Reports.

Data must be able to be transferred electronically. The Contractor shall provide the Division a reference file on standard CD or DVD media. The Contractor shall secure valid Medicaid identification numbers and names of individuals and providers for this purpose.

The following are examples of the data collection and reporting requirements for the utilization review contract:

Annual reports of the activities of Contractor shall be developed in Microsoft Access or Excel. These reports shall include: individual demographics; review outcomes by provider, region and diagnosis; frequency of specific diagnosis; and analysis of service authorization patterns. Provider outcome measures are specified in Appendix F of the contract between DMA and the vendor. Additional reporting requirements for annual

analysis will be based upon 3.16 Performance Standards. Annual report of staff and credentials conducting clinical reviews

By the 30th day following the end of each contract year, the Contractor shall provide the DMA with an annual report summarizing submission and authorization activity for the previous year. All reports must provide statewide data and breakdown by LME.

The routine reports the Contractor shall provide to the Division include but are not limited to the following:

- Authorization by Service Code,
- Authorization by Service Code and Diagnosis,
- Authorization by Service Code and Age,
- Number of Denials,
- Number of Denials per Diagnosis/Disability,
- Ratio of Denials to Authorizations,
- Number of Submissions for authorization by Method of Submission,
- CPT and HCPCs Code Authorization by Provider,
- Authorization to Denial Ratio per Contract Reviewer,
- Length of Time from Submission to Authorization, by Method of Submission;
- Ratio of Appeals to Denials;
- Comparison report from historical data to current data:
- Reduction in hospitalization utilization;
- Reduction in child residential services
- Reduction in out of state authorizations
- When child residential services are required, the majority will be served in Therapeutic Foster Care family setting
- Number and amount (units/funds) of MOS authorizations
- Timeline between denial decision and receipt of appeal
- HIPAA violations
- EPSDT Authorization report
- Provider profiling
- Significant trends from the previous quarter and other historical data that may facilitate the provision of appropriate, cost-effective services to persons with Mental Health, Substance Abuse or Developmental Disability treatment needs.
- Additional reporting requirements for routine analysis are based upon Section 3.16, “Performance Standards”.

These reports have various schedules for submission to DMA. Authorization data is submitted weekly, monthly and quarterly. Other reports are submitted quarterly with annual summary.

(vii) LME performance will be reported as part of the Mercer report mentioned above in this section. In accordance to Medicaid requirements, any vendor or LME conducting Medicaid utilization review must follow the same procedures and processes established by DMA and are subject to the same performance monitoring and sanctions.

The Contractor is responsible for the accuracy of authorization standards and applying such standards in a consistent manner between clients, services and providers. This entails the application of clinical best practices, utilizing the least restrictive and most cost-effective service option which appropriately addresses the need for which the services were authorized; and medically necessary services. Vendor monitoring and performance criteria are part of the contract and vary according to the area targeted. Performance is reviewed weekly or monthly and measures are reviewed quarterly and targets are included in the contract for established areas with financial incentives or deductions per area. These areas include but not limited to:

- Timeline for review of Services
- Review of Inpatient Services
- Electronic Review
- Notification of authorization decision to provider
- Adverse Notification letters
- Telephone Access and wait time
- Provider Relations response time and resolution
- Retrospective and post payment reviews reports submission
- Quality Assurance Reviews
- Staff Hiring and Training requirements
- Confidentiality compliance
- Recipient Eligibility compliance
- Provider enrollments compliance
- Audit of inter-rater reliability practices
- Adherence to definitions in the contract
- Invoicing standards
- Fiscal Agent Interface standards and requirements for daily data submission and error reviews
- Meetings (required and ad hoc)
- Erroneous Decisions are defined as authorizations and denials that violate an officially promulgated federal or state regulation, policy or directive. In cases of erroneous decisions, the Contractor shall reimburse the Division for the total cost to the Division of the service(s) provided in error.

Monitoring of the performance is based upon DMA review of submitted reports, random sampling of data to validate performance and accuracy of data/reports. Examples include the random selection of authorization requests submitted by the provider, review of

documentation submitted and the agreement of the decision rendered. Monitoring also includes review of complaints and timeliness and completeness of the resolution of the complaint.